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ABSTRACT

This report presents the findings of a series of meetings convened by the Department of Health and Human Services for the purpose of first, examining the health needs, priorities, and concerns of minorities; and second, considering related Federal actions. Included is an overview of the meetings' content, as well as individual chapters on the health needs of five specific populations: (1) Asian/Pacific Americans; (2) Black Americans; (3) Hispanic Americans; (4) the elderly; and (5) American Indians. For each group, meeting discussions are reviewed, focusing on: (1) prevention priorities; (2) health promotion and protection, including preventive services; and (3) implementation strategies, including grants to states and localities, research and demonstration projects, monitoring and surveillance, dissemination, technical assistance, manpower development, and direct services. Appended to the report is a list of members of each consultation group participating in the meetings. (GC)

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Strategies for Promoting Health for Specific Populations

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U.S. Public Health Service
Office of the Assistant Secretary for Health

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PREFACE

Healthy People, the Surgeon General's Report on Health Promotion and Disease Prevention, set broad goals for the Nation indicating what could be accomplished if the public and private sectors apply existing knowledge over the decade of the eighties. The priorities for action were outlined and the challenge for action was issued. More detailed and specific objectives were published in Promoting Health/Preventing Disease: Objectives for the Nation. In both of these documents, however, there could be but cursory coverage of the special needs of particular populations.

This report presents the findings derived from a series of meetings convened by the Department of Health and Human Services to examine more directly the needs, priorities and concerns of minorities and special populations in the area of health promotion, and to obtain their advice on Federal actions. The comments contained herein should prove helpful to those concerned about achieving the Objectives for the Nation. It should be noted that the suggestions of the participants are intended to encourage activity far beyond that of the Federal Government--and they do not necessarily reflect the policies of the Department.

The process which led to this report has benefited from the participation of over 500 individuals and organizations who helped select the panels of consultants; the working groups of consultants (see Appendix); and staff to the groups, including Victoria Barrera-White, Katharine Bauer, Morris Cohen, Mary Devereaux, Tuei Doong, Donald Iverson, Marland Koomsa, Henry Montes, Terri Smith Phillips and Geraldine Tompkins.

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STRATEGIES FOR PROMOTING HEALTH FOR SPECIFIC POPULATIONS

INTRODUCTION AND SUMMARY

The Office of Health Information, Health Promotion and Physical Fitness and Sports Medicine (OHP) sponsored, in 1980, a series of one-day consultation meetings for specific populations. The Washington, D.C. meetings were to provide an opportunity for specific American populations to advise the Office of Disease Prevention and Health Promotion (of which OHP is a part) on ways to ensure that the emerging national objectives for disease prevention and health promotion and the plans for implementing them respond to the health needs of these specific populations as well as the general American public. The specific populations included Asian, Black, Hispanic, and Elderly Americans, and American Indians.

The resource documents for the consultation meetings were Promoting Health/Preventing Disease: Objectives for the Nation and Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention. The goals of these two documents are 1) to increase the attention being given to disease prevention and health promotion as key elements of national health policy, and 2) to provide direction and impetus to prevention. Objectives for the Nation is a consensus of selected health experts from across the country on measurable national objectives to be attained by 1990, and in some cases 1985, in 15 distinct priority areas for action in health protection, disease prevention, and health promotion identified in the Surgeon General's Report.

Participants in the consultation meetings were asked:

- to rank and offer advice on the 15 priority areas for which objectives have been developed in health promotion, health protection, and preventive health services;
- to review strategies on ways to accomplish the health promotion objectives specifically, recognizing the social and economic circumstances affecting health that must be addressed simultaneously; and
- to make recommendations, based on the two items listed above, for agencies within the Department of Health and Human Services (DHHS) to consider in developing implementation plans for the objectives for each population.

The small working groups (see appendix) included Federal and non-Federal participants from each of the specific populations represented. The selection of five non-Federal participants was based on nominations solicited from over 600 health- and community-oriented individuals and organizations known to be knowledgeable and representative of these population groups and their health concerns. This network of individuals and organizations also offered written comments pertinent to the workshop objectives, and is now part of an ongoing process for continuing communication and consultation on future Federal

activities in disease prevention and health promotion, coordinated by ODPHP and OHP.

Each of the consultation meetings was unique. Participants brought varying experiences and views to each discussion, and they were encouraged to share their personal and professional opinions freely. Despite individual differences, there emerged for all groups some fundamental perceptions regarding the relevance of health promotion to specific populations and the adequacy of current community health activities. The views expressed by participants were based on their personal backgrounds and experiences, and were not considered to reflect necessarily the many perspectives of the larger populations they represented. However, participants were considered to be knowledgeable of the interests, concerns, and needs of their respective communities.

Health promotion was considered to be important to the special populations as an extension of ongoing, comprehensive health care delivery programs, rather than as a separate or autonomous enterprise. In fact, it frequently was asserted that health promotion programs must be conceived in relation to the overall health, social, economic, educational, and cultural environment within a community. These factors, as well as the diversity of needs and resources within a particular community, ultimately must determine the character of health promotion initiatives.

Local community organizations usually are well-qualified to define community needs and to participate in planning and implementing health promotion programs. As with health services delivery programs, lack of adequate resources has stifled such efforts in the past and is likely to be a major hurdle in the future. Nevertheless, Federal health promotion initiatives intended to benefit special populations should be developed in consultation with them and should meet the expectations raised during the planning stage.

Dr. J. Michael McGinnis, Deputy Assistant Secretary for Health (Disease Prevention and Health Promotion) opened each session by outlining the major activities of the Federal initiative in disease prevention and health promotion since the formation of an interagency task force in 1977 that identified existing Federal preventive health activities and made recommendations for future Federal programs. The coordinated planning effort, which has addressed needs, priorities, and objectives for the Nation was assisted by input from a broad spectrum of Federal agencies, health care disciplines, public and private organizations, and consumers from diverse backgrounds. The present consultation meetings grew out of the recognition that some underserved groups, whose health status may not be reflected adequately in the national profile, required concentrated analysis so that Federal planning for health promotion might more accurately reflect their needs.

Given this basic framework, each group reviewed and ranked the preventive health elements of the objectives most important to the promotion of good health for that specific population and then discussed activities, strategies,

and general considerations for accomplishing the health promotion component of the objectives.

Discussion of Priorities

The participants were asked to rank the relative importance of the five priority areas in each of the three strategy categories (health promotion, health protection, and preventive health services) designated in the Surgeon General's Report Healthy People and in the Objectives for the Nation for 1990. The three strategy categories are defined as follows:

Health promotion--any combination of health education and related organizational, environmental, and economic interventions designed to support behavior conducive to health. This category includes:

1. reducing smoking
2. reducing misuse of alcohol and drugs
3. exercise and fitness
4. improved nutrition
5. stress and violence control

Health protection--protective measures in the environment that can be used by governmental and other agencies, as well as by industries and communities, to protect people from harm. This category includes:

6. injury control
7. occupational safety and health
8. dental health protection
9. toxic agent control
10. infectious agent control

Preventive health services--key preventive services that can be delivered to individuals by health providers. These include services such as:

11. family planning
12. pregnancy and infant care
13. immunizations
14. sexually transmissible disease services
15. hypertension control

Participants in the consultation meetings accepted the Objectives for the Nation as a working document which could be adapted to reflect more accurately the most significant needs of specific populations. Adaptation would involve, for example, recognition of the leading cause of illness and death for each group as a determinant of program priorities in health promotion, health protection, and preventive health services. In some instances, terminology would have to be modified (e.g., "family planning" would replace references to "birth control") to make Objectives for the Nation a more acceptable working document.

The five groups ranked the 15 priorities differently. (Details of the rankings are contained in the individual group reports.) Most groups added one or more new priorities (such as vision care, school health education, and human sexuality) and insights (such as the importance of a family-centered approach to health among Hispanics) that can contribute to the development of tailored, and consequently more effective, approaches to health promotion, health protection, and preventive health services in those populations.

Recommendations for Implementation Strategies

The afternoon session focused more closely on activities and strategies for accomplishing the health promotion objectives, taking into account the current activities of the Public Health Service, particularly those of the Office of Health Information, Health Promotion and Physical Fitness and Sports Medicine (OHP), the Bureau of Health Education (now called the Center for Health Promotion and Education), the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), the Office on Smoking and Health (OSH), and the President's Council on Physical Fitness and Sports (FS).

Dr. Lawrence W. Green, Director of OHP, described the origin and development of the Office, major activities being undertaken, and the emerging National Health Promotion Program for the 1980s. The National Health Promotion Program aims to identify and encourage personal and public health practices that can make the greatest improvements in health. Given numerous constraints, these strategies must help the public, health professionals, and decisionmakers in both the public and private sectors in their voluntary adoption of health-enhancing behaviors.

In order to achieve the ultimate goals of a healthy population, Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention identified the major health problems and their associated risks at each of the five principal stages of life, and it presented quantified goals to be achieved by the year 1990.

The 15 priorities for disease prevention, health protection, and health promotion are flexible in the sense that they may be modified to meet local health needs and conditions. The objectives for the Nation are to provide a framework for efforts to improve health over the next decade.

The discussion then focused on recommendations and issues related to implementation strategies for the objectives in health promotion. These recommendations were centered around the mechanisms available to the DHHS in implementing the ational Health Promotion Program:

- Grants to States and localities
- Research and demonstrations
- Monitoring and surveillance
- Dissemination
- Technical assistance
- Manpower development, and
- Direct services.

A summary of the groups' comments and recommendations follows.

Grants to States and Localities. Because States frequently do not act in the interest of special populations when dispensing Federal funds and other resources for health programs, the Federal Government should assume a strong, highly visible role in the development of health promotion programs. With respect to American Indians, the historical relationship with the Federal Government has rendered questionable their eligibility to receive grant funds from State agencies. Additionally, grant funds typically are inadequate to meet community needs and allow for follow-through on commitments verbalized by Federal programs. In response to these circumstances, participants recommended that the Department (1) encourage the development of more cooperative, rather than competitive, efforts among community groups; (2) earmark funds specifically for special populations; (3) make more long-term funding commitments; (4) involve multi-ethnic groups in the review and monitoring of grant applicants; (5) increase coordination between State and local agencies (such as Health Systems Agencies and Agencies on Aging); and (6) increase coverage for preventive health services under existing health care financing and social services programs.

Research and Demonstrations. Participants generally agreed on the need for more accurate data on the health status and health needs of special populations, and for employing existing community organizations to supplement data obtained through federally-funded surveys and studies. Special populations should be included in planning, conducting, and analyzing research on health care and health promotion (e.g., research on effective ways to encourage change in health behavior). Cultural factors should be considered in establishing research protocols and designing research instruments.

Monitoring and Surveillance. Less was said about monitoring and surveillance than about other mechanisms utilized by Federal programs to foster health promotion activities. It was recognized, however, that quality monitoring and surveillance activities can help to establish local baselines against which to evaluate progress and ensure compliance with Federal guidelines. Indigenous community residents and health workers should be involved in data collection and analysis, and monitoring and surveillance instruments should include items on risk factors and health behaviors relevant to the communities studied.

Dissemination. Several themes were reiterated in the course of the discussions on dissemination. These included (1) increasing the use of media serving special populations and other communications channels at the State and local levels; (2) developing culturally-sensitive educational materials and media messages; and (3) aggressively disseminating these materials to special populations through community-based organizations and the Social Security system, for example.

Technical Assistance. Participants pointed out that the Federal Government should assume a more active role in identifying technical assistance needs of special populations before requests are made or problems arise. Technical assistance is especially needed (1) to help special populations learn more about working effectively within the bureaucracy; (2) to help Federal and State personnel work more effectively with special populations; (3) to aid these groups in preparing grant applications and contract proposals; and (4) to enhance program implementation and evaluation. Minority, elderly, and Indian organizations should be utilized to provide technical assistance.

Manpower Development. Federally-sponsored health professional training efforts offer many opportunities to further health promotion among special populations. The consultation meetings revealed that these efforts could be strengthened by expanding the recruitment of special populations, and by requiring specific training in health promotion and preventive health interventions for practitioners working in medically underserved areas. Utilization of allied health professionals to provide health education also was recommended. Participants considered it important that health professionals be sensitized to cultural aspects of special population groups and the influence of cultural factors on health.

Direct Services. There are many service delivery settings (including religious and civic organizations, foster care settings, and the home) where greater attention needs to be given to health promotion. Participants concluded that without additional resources and trained staff, existing health care programs would be severely restricted in their ability to address health promotion. Provision of comprehensive, well-coordinated, and accessible health services was clearly of the utmost importance.

Conclusion

The consultation meetings were beneficial to the OHP and to other Federal participants. Recommendations and comments obtained from the meetings will be used to provide decisionmakers with the special populations' perspectives on the Objectives for the Nation and to influence the development of health promotion plans and policies within the Department of Health and Human Services. The names and addresses of the 600 minority, Indians, and elderly individuals contacted during the planning phase were sent to the Office of Consumer Affairs to be used as a source of knowledge regarding consumer concerns of special populations. These individuals are now part of a network with which OHP will interact in carrying out future activities.

ASIAN/PACIFIC AMERICANS

The following is a presentation of views expressed by participants during the meeting on strategies for promoting health for Asian/Pacific Americans.

Asian Americans and Pacific Islanders are a diversified population in terms of culture, language, and health status and needs. This diversification is due to such factors as country of origin, duration of residence in the United States, and socio-demographic conditions. The language and cultural differences have often created barriers that exclude many Asian/Pacific Americans from the mainstream of American life.

The health concerns of Asian/Pacific Americans have been neither accurately nor adequately reflected in many resource documents and aggregate statistical compilations, including Healthy People and Promoting Health/Preventing Disease: Objectives for the Nation. Asian/Pacific Americans themselves are best able to define and address the needs of this population, through the planning, implementation, and evaluation of health promotion programs. The Federal Government should play an active role to facilitate this process. In many localities Asian/Pacific Americans make up a relatively small percentage of the total population and, therefore, have limited strength at the local level. Relative to other groups, these groups will not benefit much from decentralized health promotion programs unless special provisions are made by the Federal Government.

Discussion of Prevention Priorities

When asked to indicate the relative importance of the five priority areas within each of the three strategy categories (health promotion, health protection, and preventive health services), the participants did so according to the perceived importance to each of three population subgroups. The participants were reluctant to address prevention priorities because of a lack of complete statistical data on the health of Asian/Pacific Americans and the inability to speak for all the different groups.

The subgroups include:

Pacific Islanders--Rankings were not done for this group, which includes Americans from Hawaii, Fiji, Guam, Samoa, and Trust Territories. The participants felt that their combined knowledge was inadequate to accurately present the views of this group. A recommendation was made to consult members of this subgroup and national associations later for their priorities and comments.

Immigrants--This group includes first or second generation Asian/Pacific Americans who speak English as a second language.

Asian-Americans--This group is comprised of persons who have become more integrated into the mainstream of American life, although they are of diverse socio-economic status.

Refugees--These are persons who have most recently arrived from Vietnam, Cambodia, Laos, Pakistan, and other countries. The health status of refugees is often related to their circumstances when entering this country. Their immediate health needs are influenced by the conditions within the refugee camps in the first country of asylum, the length of stay there, and the overall stress inherent in such transitory situations.

Although most refugees are Indochinese, further differentiation exists among urban, rural, hill tribes, and other ethnic minority refugee groups. Refugees from hill tribes, for example, may take a more spiritual and less "westernized" approach to health care than those from urban areas. This is just one of the cultural differences that must be kept in mind by people who are planning health interventions.

Participants ranked prevention areas with the qualification that these priorities were based only on their perceptions and should be refined when more data can be obtained. The proposed rankings are shown in table 1. The rankings are intended to show in which areas the participants feel major attention should be directed.

Table 1. Ranking of Importance: Asian/Pacific Americans

Scale: 1 = high; 5 = low

Promotion/Prevention Category	Refugees	Immigrants	Asian-Americans
Health Promotion			
Smoking Cessation	4	4	3
Misuse of Alcohol and Drugs	2.5	2.5	1
Exercise and Fitness	5	5	4.5
Improved Nutrition	2.5	2.5	4.5
Stress Control	1	1	2
Health Protection			
Injury Control	1.5	3	2
Occupational Safety and Health	1.5	1	1
Dental Health Protection	4	4	3
Toxic Agent Control	5	5	5
Infectious Agent Control	1	2	4
Preventive Health Services			
Family Planning	3	2	2
Pregnancy and Infant Care	2	3	3
Immunizations	1	5	6
Sexually Transmissible Disease Services	5	6	5
Hypertension Control	4	1	1
Vision Care*	not ranked		

*Category added by participants as especially applicable for this group.

Comments by Participants Regarding Specific Priorities

Health Promotion

Nutrition--Health promotion programs should be capable of emphasizing the healthful aspects of a native diet. American food is not necessarily better. Asian-American people need to learn how to combine the best aspects of native cooking with readily available American foods in a manner that is palatable to them. Health providers need to gain an understanding of native diets, so that elements of the native diet can be fully integrated into special dietary regimens.

Exercise and Fitness--Exercise becomes important when viewed against the abundance of food in America and the sedentary lifestyle to which many newly-arrived persons may not be accustomed.

Stress Control--A special source of stress among refugees and immigrants arises from the problems associated with adjustments to life in America. Newly-arrived persons often feel a sense of "alienation, hopelessness, and powerlessness" often associated with a need to re-learn basic survival skills and a loss of occupational status. The elderly are another group at special risk of stress. The available mental health system is deemed inappropriate. Community mental health interventions for isolated elderly persons or a combination of mental and physical health services are needed.

- underemployed persons (forced to accept jobs unrelated to their technical skills, education, training, and/or experience);
- unemployed persons (those who are unskilled and/or without English language capability);
- persons who have married outside of their cultural group;
- adolescents;
- single males; and
- single heads of households.

Health Protection

Infectious Agent Control--Refugees from Southeast Asia are experiencing a significant rate of positive tuberculosis skin tests and hepatitis B. Some refugees get multiple skin tests in a short period of time because of an inadequate health records system. Strict immigration laws have forced some persons to obtain healthy x-rays illicitly so as to be able to emigrate.

Occupational Safety and Health--Some Asian/Pacific Americans are exploited by employers and some unions and are working for low wages without adequate attention to their safety and future health. Many workers are required to pay union dues, only to find that their interests are not represented.

Immunization--Tracking has presented a problem in the past, but a new system being implemented in Asian refugee camps should help to alleviate the problem. Under this system, all refugees should arrive with a complete medical record. The lack of bilingual health personnel and educational materials has created difficulties for refugees getting immunizations in the U.S.

Preventive Health Services

Family Planning--Women are often more employable at available low-paying jobs than men. Many Asian/Pacific American women have to work to help support a large extended family. Such women have a special need for family planning services that are accessible and culturally appropriate.

Recommendations for Implementation Strategies

The following are the specific comments and recommendations put forward by the Asian/Pacific American consultation group relative to implementation strategies for the objectives in health promotion.

Grants to States and Localities (Health Education/Risk Reduction Grants)

1. Ethnic subgroups should be considered in determining funding allocations, even if it means special funds set aside for specific groups for the development of specially designed Federal programs. A strong Federal role should be emphasized.

2. Health care financing mechanisms should be provided so that preventive health services are not entirely grant-dependent. Reimbursement for patient counseling and community-oriented health promotion activities should be based on overhead, rather than fee-for-service.

3. Decentralization may mean a loss of services for minority groups. For example, the Federal Office of Refugee Resettlement has recently terminated its provision of mental health services to refugees. This responsibility will be delegated to States under the Title XX program, but there is no guarantee that States will fulfill their responsibilities. Local and State resources cannot adequately provide services for refugees, who are the most disenfranchised group.

4. States may use minority persons as consultants to secure grant money; yet this often seems like mere "tokenism" and is not adequately reflected in services to the minority group once the State obtains the funding.

Research and Demonstration

1. There is a general lack of statistical data on the health needs of the many cultural groups within this population. Community-based programs and organizations, however, are collecting data of

variable quality regarding those whom they serve. More current data, especially socio-demographic data, are needed on specific ethnic groups. Specific data needs include the following:

- the country or region from which Asian/Pacific Americans originate (especially refugees and recent migrants);
- whether the immigrant is an urban, hill tribe, or rural refugee;
- specifications and conditions of various refugee camps; and
- more information on Pacific Islanders, in general (to include Samoa, Guam and Fiji Islands).

2. Alternate ways to interpret data on Asian/Pacific American communities are needed. Simple aggregation methods are not always applicable.

3. Small communities of Asian-Americans of diverse ethnic backgrounds may be dispersed throughout several census tracts within a large city. Alternative methods of collecting and interpreting census data are needed. Community-based organizations and academic institutions should be more involved in planning, developing, and implementing research projects. More collaboration is needed between State, local, and community projects.

4. The success of data collection and surveying efforts will depend on the development of Asian/Pacific Americans in the process. Asian-American contractors can provide staff for research projects, thus improving acceptability. The 1978 Task Force Report on Asian/Pacific Mental Health recommended that more community-oriented research be undertaken.

5. There is a need to pool statistics and review survey data already collected.

Monitoring and Surveillance

Guidance on evaluation methods for the community level are needed.

Dissemination

1. The Federal Government should work with community-based and national nonprofit and voluntary organizations, but should develop a mechanism to assure that these groups are responsible to the needs of the people.

2. For large communities, more than one local organization will be needed to reach the several enclaves of Asian/Pacific American groups.

3. Bilingual and bicultural educational materials are needed. As demonstrated by an NIMH-funded study, it has been difficult to obtain funds for their production. Bilingual materials should include tapes or other video materials suitable for nonreaders. The Center for Applied Linguistics in Washington, D.C., is one of many sources which can provide translation services in Indochinese languages.

4. Follow-up is needed as part of health education services after written and oral information has been given. There must be supplemental interpersonal communications.

Technical Assistance

1. Assistance is needed in the grant application research and evaluation process. The Asian-Pacific American Federal Employees Council may provide expertise in planning for technical assistance from the Federal Government.

2. To qualify for Federal contract money, small Asian-American contractors may need to pool their resources. The Federal Government should provide technical assistance to help these organizations do the work in their own communities.

3. Technical assistance with evaluation of health promotion activities would be especially appreciated by local community organizations. Evaluation materials that take into account specific cultural influences on behavior are needed to assess the long-range effects of health promotion activities.

4. Interagency agreements on technical assistance need to be developed.

Manpower Development

1. Better trained health professionals are needed. Interpreters with no health background are less helpful in providing health services. Assistance is needed in locating and training professional staff members to provide preventive health services.

2. Trained professionals from foreign countries are often a lost manpower resource. Many trained immigrants are unable to practice because of language barriers. Policies regarding the granting of licenses and credentials should be amended. Improved reciprocity policies between States should be encouraged to permit temporary practice while licensure is pending. There are barriers to licensure and certification examinations that could be eradicated through Federally-sponsored preparatory courses and more in-service training with an emphasis on English to improve test-taking skills of foreign health professionals.

3. While many Asian/Pacific Americans have entered the health professions, few specialize in primary care and prevention. There

is a need to retrain foreign professionals and redistribute manpower to underserved areas.

4. Sensitivity to ethnic needs should be a regular part of medical and social services school curricula. More in-service and continuing education is needed for traditional providers (physicians, nurses, social workers, etc.).

5. Where there is a short supply of medical specialists with an appropriate ethnic background, assistance is needed in preparing non-ethnic specialists for continued referrals and follow-up consultations (a provider-to-provider link). This would include language interpretation and instruction to generate a sensitivity to cultural factors.

Direct Services

1. Health services, in general, should be made more accessible. The available services often are inappropriate, and are delivered by persons who lack bilingual capabilities and bicultural sensitivity.

2. Because the need is greater than for many other groups, a demonstrated services utilization rate that is proportionate to that for the rest of the population means that needs are not being adequately met.

3. Health services should be provided for the working poor. Immigration laws state that a person is deportable if public assistance is accepted within five years of arrival in this country. This accounts for the reluctance of many Asian/Pacific Americans to accept any public assistance, including necessary health services. It should be kept in mind that any national health insurance program would not cover the thousands of persons who are not yet American citizens.

BLACK AMERICANS

The following is a presentation of views expressed by participants during the meeting on strategies for promoting health for Black Americans.

From a Black perspective, any serious discussion of national policies and objectives in health promotion must first address the criticism that health promotion reinforces current tendencies to blame the individual for his/her less than optimal health condition. Any rational strategy for improving the health status of the poor and minorities must be viewed from the perspective of comprehensive health care.

Whether through fault of each individual, society at large, or a combination thereof, Black people occupy a disproportionately low health status. Health promotion programs properly designed and sensitively administered can have a great impact on certain subgroups of the Black population which are receptive to positive health messages. Such subgroups include: pregnant women (teens and adults); new mothers; young Black males; and preschool, primary grade, and junior high school children. Health promotion programs, in general, can have a positive effect within Black communities. If people are being asked to modify their health behavior, society must also become more aggressive in its effort to modify its behavior toward people in order to expedite change.

In an effort to decentralize health promotion and disease prevention activities, it is important to determine which structure and level of government can be most effective in strategy implementation. In this process people with whom local groups can identify and associate must play an active role. Local development and implementation should be carried out through existing community structures and agencies which are better able to address the concerns of ethnic minorities.

Objectives for the Nation is a document that groups can work from; yet specific revisions need to be made in order to fulfill the needs of targeted groups. Guidelines must be developed to help local groups adapt and implement programs addressing the specific objectives. There is a need for a policy statement at the national level on health status of Blacks and other specific population groups which would be enforced and monitored at the Federal level. The ODPHP and OHP should play an advocacy role in promoting health in minority populations.

Health promotion must be pursued in light of other factors. Some diseases and debilitating conditions are provoked by the stress and strain associated with day-to-day coping, inadequate education, and other obstacles within the social and economic environments. It is difficult to speak seriously of health promotion in the Black community without due consideration to general

medical care and other services which impact on health. Funds for other services should not be reduced to make money available for health promotion programs. Too many have been deprived of decent housing, jobs, and educational opportunities. These must accompany health promotion strategies. No health strategy in isolation from basic changes in the social fabric of the Nation will truly address the needs of minorities and the poor.

Although willing to contribute their individual opinions regarding health promotion and the Black community, the group was particularly reluctant to speak for all Black Americans. Participants cautioned that the health needs of specific socio-economic groups within the Black community vary widely and that more information should be gathered at the local and regional levels. Dr. Lawrence Green, Director, Office of Health Information, Health Promotion and Physical Fitness and Sports Medicine, assured the participants that they were convened to offer individual expertise and experiences as members of the Black American population, but were not expected to represent nor speak for the total Black population.

It was asserted that minority groups should be consulted throughout all steps in the planning of any major Federal initiative. A mechanism should be developed for coordinating ideas and information from many different groups and subgroups.

Discussion of Prevention Priority Areas

The participants' assessment of the relative importance of the five priority areas in each of the three strategy categories (health promotion, health protection, and preventive health services) is shown in table 2.

Table 2. Ranking of Importance: Black Americans

Scale: 1 = high; 5 = low

Promotion/Prevention Areas	Rankings
Health Promotion	
Smoking Cessation	4
Misuse of Alcohol and Drugs (see below under stress control)	not ranked
Exercise and Fitness	5
Improved Nutrition	1
Stress Control	
- Drug and Alcohol Abuse, Suicide, and Homicide Prevention*	2
- Psychological-Social Support*	3
Health Protection	
Injury Control	1
Occupational Safety and Health	2
Dental Health Protection	5
Toxic Agent Control	3.5
Infectious Agent Control	3.5
Preventive Health Services	
Family Planning	4
Pregnancy and Infant Care	1
Immunizations	5
Sexually Transmissible Disease Services	6
Hypertension Control	2
Dental Health Services*	3

*The five original areas under each category as they appear in the PHS documents are shown on the left. Items added by participants as especially applicable for the Black population are marked with asterisks.

Comments by Participants Regarding Specific Priority Areas

The relative importance of each area will vary for different age groups in the Black population. The leading contributors to death among Blacks (hypertension, homicide, infant mortality, cancer, poor nutrition) are important variables in setting priorities for health programs, although the objectives for the Nation in disease prevention and health promotion are not disease-specific. Additional comments were made on specific areas.

Health Promotion

The participants agreed that the added areas--drug and alcohol abuse, suicide and homicide prevention, and psychological social support--are closely related to stress control. Coping with day-to-day pressures and demands experienced by underserved and economically deprived Blacks often takes the form of alcohol/drug abuse, suicide/homicide, and psychological malfunctions. Because of the prevalence of stress-related problems, these areas were combined and given rankings as elements of stress control.

Preventive Health Services

The delivery of direct dental health services needs to be given more attention in the Black population. This is in addition to the dental health protective measures that can be taken at the community, industry, and State and local government levels.

Recommendations for Implementation Strategies

The following are the specific comments and recommendations of the Black American Consultation Group related to implementation strategies for the objectives in health promotion.

Grants to States and Localities (Health Education/Risk Reduction Grants

1. For Blacks, most leverage has been gained where the Federal Government has taken an active role in program implementation. In some geographical areas the primary thrust should be Federal; for other areas the State can have the biggest impact. This needs to be considered in resource planning and allocation.

2. Financial resources (and time) are often lacking when implementation is to take place, after community awareness and interest have been raised.

3. Minority groups often end up competing for the same funding. There needs to be more cooperation and sharing of interests. Special populations, not only Blacks, are not monolithic, but consist of multiple communities. Commonalities and differences need to be identified, possibly through a joint, multi-ethnic assembly.

4. Within a given State or city budget, funds should be clearly earmarked for minority programs that are not city or State programs. The percentage of total prevention/promotion funds allocated to minorities should be identified. The percentage should be greater than the percentage of the population which is minority, because of the disproportionate amount of health problems minority populations have.

5. Multi-ethnic groups should be actively involved in the review of grant applications.

6. Resources should be made available to facilitator groups that often do not receive Federal support, but are already involved in grass-roots, community-based activities. These groups also can help generate a willingness among community residents to participate in programs. (The National High Blood Pressure Education Program, supported by the National Heart, Lung, and Blood Institute developed an effective model for using these groups.)

7. Federal backing is needed to assure implementation of State and local health plans in a manner consistent with Federal guidelines. An appeals process is needed to give community groups direct access to the Federal Government when a discrepancy exists between local health needs and apportionment of funds by local and State governments.

8. Under the current system, community-based organizations must depend largely on short-term project funds. Long-term funding commitments would help assure continued coordination of efforts.

Research and Demonstration

1. Present health statistics are not always an accurate indicator of what really is needed or what should be done. More data are needed on the health status of Black Americans so that funds can be provided more appropriately where they are most needed. Statistics on minority populations should be disaggregated.

2. There are various sources of data pertinent to Blacks that should be used to supplement information available from government agencies in planning health promotion programs. These include survey data from the National Urban League, university-based minority investigations, and studies conducted by voluntary health associations.

Monitoring and Surveillance

Program monitoring systems should ensure compliance with Federal guidelines. DHHS should withhold funds from noncomplying State and local agencies. Black advisory groups should be involved in the monitoring process.

Dissemination

1. In developing, pretesting, and disseminating information through various media, Federal programs should make use of persons who are familiar with the target population. Contracts should be made available to minority populations for the development, evaluation, and distribution of materials.

2. Materials developed for nationwide use should allow for "local tagging" to indicate where consumers can go for help or to obtain additional information.

3. National media programs should work cooperatively with the Black media and communications network at the State and local levels to achieve optimum support mechanisms.

4. Local media personnel should be provided with a yearly plan regarding what messages will be available and when, so that these communications can be built into local programming.

Technical Assistance

1. The Federal Government should take an active role in locating those who may need assistance, rather than waiting for groups to ask for help. The Federal Government should provide assistance directly to Black communities, or develop independent centers for technical assistance.

2. The Federal Government might act as a buffer, assuring coordination and cooperation between HSAs, voluntary health organizations, and local and State health departments. Voluntary agencies have expanded beyond traditional roles to include more health promotion activities, which often overlap with State/local government activities. Assistance in outreach and Federal-community interchange should be undertaken actively rather than passively, as was the strategy in the Office of Economic Opportunity.

3. Community groups need assistance in the application process for Federal grants and contracts. (A publication on grant writing for minority researchers will be available soon from the Center for Minority Group Mental Health Programs.)

4. Technical assistance is primarily needed in two ways:

   a. Helping minority groups learn more about working within the bureaucracy; and

   b. Helping Federal and State personnel learn more about working with minorities.

Manpower Development

1. Black health professionals who can effectively deal with minority groups (and this requires careful selection) are needed to assist in identifying health problems, resources, and programs. A comprehensive integration and utilization of all health professionals is needed for the effective implementation of any health strategy.

2. Training is needed to provide staff members at health systems agencies with the skills needed to work effectively with minority groups.

3. All health professionals, particularly minorities, should be educators. This should be emphasized in Black colleges and universities. Money should be provided for the training of Black health educators and Black physicians who will work within the Black community as social change agents and community organizers to assist in informing the community of the importance of individual behavior and lifestyle as factors affecting health, illness, disability, and premature death. Black educational institutions should have health services, health education programs, and environmental conditions which provide examples and models for everyday living.

4. Funds should be provided to support additional staff members for local health centers and to enable additional training of current staff members so that health promotion programs can be implemented. The effectiveness of nonprofessional indigenous community health workers should be assessed and increased in community projects, where appropriate.

5. Improved outreach is needed to recruit Blacks for programs such as the National Health Service Corps Scholarship Program and the Commissioned Corps, both of which provide funding for medical training in return for services. Young physicians who are members of the National Health Service Corps and the Commissioned Corps and who will be working in underserved areas should receive training in health promotion and preventive health interventions and should have the appropriate attitude for dealing with minority groups.

Direct Services

There are many service delivery settings and programs where more attention needs to be given to the Black population, especially in terms of health promotion:

1. Detention and correctional institutions.

2. Foster care settings for children.

3. The home, especially as a place to reach preschool-age children (and their parents).

4. The military health care.

5. Urban parks.

6. Sports programs.

7. Religious, social, and civic organizations and programs.

8. Welfare agencies and unemployment offices.

HISPANIC AMERICANS

The following is a presentation of views expressed by participants during the meeting on strategies for promoting health for Hispanic Americans.

A major concern of the Hispanic consultation group was that they not be viewed as representing all Hispanic Americans.

It was emphasized that the Hispanic population within the United States is diverse. It includes Americans of all socioeconomic strata from Cuba, Puerto Rico, Mexico, and other countries of Central and South America and the Caribbean. Health status and needs vary widely and are associated with cultural differences, socioeconomic circumstances, and length of residence in the United States. Planning for disease prevention and health promotion strategies must take these differences into account.

Participants voiced frustration because of an overall lack of accessible and culturally appropriate general health services for many Hispanic groups. Participants also expressed disappointment with what they see as a continual lack of coordination between the Public Health Service (PHS), which is establishing objectives for the maintenance and promotion of health, and the Health Care Financing Administration, which provides funding for public health services based on a fee-for-service, curative approach. A funding mechanism is needed which more adequately corresponds to PHS goals. The group requested a meeting with the Secretary of the Department of Health and Human Services and the Assistant Secretary for Health to present a substantiated rationale for better coordination between these principal operating components of the Department.

If emerging health promotion programs are truly to meet the needs of the people, planning and decisions should be made at the local level by members of Hispanic subgroups who are most knowledgeable about the service needs. Health promotion activities such as those described in the Surgeon General's Report, Healthy People, also require resources that are currently unavailable in many communities (e.g., bilingual-bicultural materials, program funds, etc.). Participants cautioned that it would be unwise to raise expectations about programs or health goals which they feel may never be available or affordable in Hispanic communities. Social and economic barriers must be addrssed in a disease prevention/health promotion plan aimed at Hispanic Americans.

Discussion of Prevention Priority Areas

The consultation group ranked the five priority areas in each of the three strategy categories (health promotion, health protection, and preventive health services) according to the perceived importance of each to eight subgroups within the Hispanic community. The eight subgroups were devised and given individual attention in the rankings to emphasize the diversity and regionalization of the Hispanic population. The Hispanic subgroups and the proposed rankings are shown in table 3. The rankings are intended to indicate the areas participants feel deserve the most attention.

Table 3. Ranking of Importance: Hispanic Americans

Scale: 1 = high, 5 = low

Promotion/Prevention Areas	Urban Chicanos	Rural Chicanos	Migrant Chicanos	Mainland Puerto Ricans	Island Puerto Ricans	Cuban Refugees	Other Cubans Americans	Undocumented-Workers
Health Promotion								
Smoking Cessation	7	6	5	7	6	4	2	**
Misuse of Alcohol and Drugs	1	2	3	2	1	3	1	2
Exercise and Fitness	6	7	**	6	5	**	6	**
Improved Nutrition	2	1	1	3	2	2	7	1
Stress Control	3	3	2	4	3	1	3	3
Human Sexuality*	5	5	**	5	**	**	5	**
Comprehensive School Health Education Program*	4	4	4	1	4	5	4	**
Health Protection								
Injury Control	3	3	3.5	2	3	5	5	2.5
Occupational Safety and Health	1	2	3.5	3	2	4	3	2.5
Dental Health Protection	6	6	6	5	6	3	2	**
Toxic Agent Control	4	4	1	6	4	6	6	5
Infectious Agent Control	5	5	5	4	5	2	4	4
Housing*	2	1	2	1	1	1	1	1
Preventive Health Services*								
Family Planning								
Pregnancy and Infant Care								
Immunizations								
Sexually Transmissible Disease Services								
Hypertension Control								
Comprehensive Family Health Care*	1	1	1	1	1	1	1	1

*Category added by participants as especially applicable for this group.
**Indicates participants considered category unimportant for a specific group.
***Participants did not wish to separate specific preventive health services, perferring to emphasize the importance of a comprehensive family-centered approach.

Comments by Participants Regarding Specific Priority Area

Health Protection

Injury Control--There is a high death rate from accidents among Chicano migrant children, especially from automobile accidents and drowning.

Toxic Agent Control--The Hispanic population, especially the migrant workers, need to be made more aware of the dangers of contact with pesticides. It is felt that death certificates and other statistics do not adequately reflect the true extent of the problem. Health personnel are needed to help detect toxic agents and provide the necessary education and referrals.

Dental Health Protection--Dental health services and protective measures are considered important but are not an affordable necessity for some Hispanic groups.

Preventive Health Services

The family is of utmost importance to all Hispanics. There was consensus among participants that all health services should be available in one place, with the major emphasis on the family. Even mental health problems such as alcohol and drug abuse should be dealt with from the family perspective. Participants did not wish to rank specific areas of preventive health services because of the importance of their being considered comprehensively.

Immunizations--Participants felt that the 90 percent immunization rate achieved in the majority of the U.S. population has not been achieved within most Hispanic groups, especially migrants; therefore, emphasis must be placed on improving these rates for Hispanics.

Family Planning--The term "family planning" itself is barely acceptable as a euphemism, but "birth control" and "contraception" carry unacceptable connotations. The most acceptable term would be "comprehensive maternal and child health services," which includes family planning, pregnancy and infant care, and nutrition services for mothers and infants.

Recommendations for Implementation Strategies

The following are the specific comments and recommendations of the Hispanic American consultation group related to implementation strategies for the objectives in health promotion.

Grants to States and Localities (Health Education/Risk Reduction Grants)

1. Federal involvement needs to be developed beyond the existing grant mechanism to assure fair access for Hispanic communities.

2. Allocation of funds should be based on regional needs. A needs assessment would be necessary.

3. National Hispanic organizations should be involved in the review of State health plans and grant applications to assure appropriate and fair access for Hispanic communities with regard to need.

4. Under the current arrangement, States submit only those grant applications considered by State officials to be most appropriate. A mechanism should be set up whereby the Center for Health Promotion and Education (formerly the Bureau of Health Education) will at least see all proposals submitted to State agencies for consideration under this program. A special provision might be created for review of rejected proposals.

5. Grants, rather than contracts, should be used more often for program development and implementation at the local level.

6. Hispanic Americans are often asked for advice during planning, but when a grant is awarded, services may not be distributed equitably. This practice must be corrected.

7. Health systems agencies should coordinate their efforts with those of area Agencies on Aging when planning and implementing health programs. This need has become evident from the failure of these planning mechanisms to address adequately the needs of the Hispanic elderly.

8. Migrant Head Start programs are funded directly with Federal money. This might be a prototype of funding for some health promotion projects for minority groups.

9. A new category of grants, possibly developmental grants, needs to be established to enable local groups to determine the needs within their communities before applying for program grants, even when the State applies for grants.

Research and Demonstration

1. Good baseline statistics are needed.

2, Cultural factors should be considered in establishing norms for research. Research protocols should be developed with an awareness of how cultural factors influence health behaviors. Hispanic data should be disaggregated because Hispanics are not a homogeneous group. Because of differences in culture and behavior, evaluation instruments should be developed especially for use with Hispanics. Translations of Anglo instruments are not appropriate.

3. Community groups need to be involved in the basic planning of research activities and in the actual conduct of research.

4. Some existing research data on migrants and others should be either discarded or critically reexamined.

5. Sources of information used by OHP in preparing for the session or mentioned by participants as helpful in determining the needs of Hispanic groups included the following:

   a) Monograph #2: Hispanic Intermarriage in New York City, 1975, Joseph Fitzpatrick and Douglas Gurak, the Hispanic Research Center, Fordham University, Bronx, New York, 1979.

   b) First Conference on Hypertension Among Puerto Ricans: Summary Report, the Ad Hoc Committee on Hypertension in Minority Populations of the National High Blood Pressure Education Program, National Heart, Lung, and Blood Institute, NIH Publication No. 80-1962, April 1980.

   c) The Health of Mexican Americans in South Texas, a report by the Mexican American Policy Research Project, The LBJ School of Public Affairs, 1979, University of Texas, Austin, Texas.

   d) The Health and Nutrition Examination Survey, to be conducted for Hispanic groups in the near future by the National Center for Health Statistics. (For more information about this survey, contact Kurt Maurer at (301) 436-7081.)

   e) Puerto Ricans and Health: Findings from New York City, José Oscar Aler, Hispanic Research Center, Fordham University, Bronx, New York, 1978.

Monitoring and Surveillance

1. Needed are local baselines by which to evaluate progress, with protocols written or administered by Hispanics.

2. Monitoring for evaluation purposes should be supportive rather than punitive.

3. Certain parts of the Health and Nutrition Examination Survey must be carried out by community groups to assess local needs of Hispanics in relation to the nationwide needs of Hispanics. This survey can be repeated at intervals to permit tracking of certain measures.

4. Funding should be provided to allow for site visits to monitor the activities of Federal grantees and contractors. These visits and assessments could be collaborative with other Federal departments and agencies.

Dissemination

1. Educational materials and audio-visual instruments should be available for people who can read and for those who cannot. Illiteracy is still a problem among Hispanic Americans. Many Hispanics read only English. Bilingual written materials that are not simply translations from the English are needed.

2. Radio has been used effectively to reach some Hispanic people and should be further explored in health promotion activities.

3. Local, community-based organizations (churches, civic groups, schools) involving people who understand cultural values, sex roles, and the language, for example, need to be better utilized for program development. Ethnic leadership can be identified through national associations, regional and local affiliates, other networks and constituencies. The Comptroller's Office, Department of Health and Human Services, has rosters of Hispanic organizations that have to be reviewed and updated for optimal use.

4. Examples of materials that have been useful include:

   a) bilingual literature provided by NIAAA, and

   b) the mass media campaign of the National High Blood Pressure Education Program.

Technical Assistance

1. The Federal Government should seek out those who need assistance, rather than merely responding to groups requesting assistance.

2. Assistance is needed in how to write effective funding proposals.

3. A better listing is needed of minority (8-A) consulting firms which are not merely being included as "tokenism."

4. Technical assistance consultants must be bilingual and bicultural.

5. Grants or purchase orders may be more appropriate than contracts for financing short-term technical assistance.

Manpower Development

1. Hispanic health professionals and Hispanic-controlled health services are lacking and this must be addressed.

2. Culturally sensitive paraprofessionals are needed. In-service training and continuing education should acquaint health professionals with cultural and ethnic differences within the Hispanic community. Health educators should be trained in cultural awareness as part of their core curriculum. A pamphlet developed by the New Mexico Health Department to improve the cultural sensitivity of public health nurses has proved effective. This might serve as a model for other materials.

3. Early education to acquaint Hispanic children with appropriate health provider role models is needed to encourage an understanding of and an interest in the health professions.

4. Help is needed by Hispanics in gaining entrance to schools for training health professionals. Many scholarships are accessible only to those already accepted by or attending a better school.

5. Clientele characteristics must be taken into account in hiring professional and paraprofessional staff, so that the bilingual-bicultural client receives services from persons best able to deal with them culturally and linguistically.

Direct Services

1. Community health centers are overburdened already and will have difficulty providing preventive services unless additional resources are available. An infrastructure is needed so that these centers can deal simultaneously with acute problems and health promotion services. This will require not only additional funds but trained staff.

2. Community mental health centers are not meeting the needs of Hispanic groups for mental health services and for substance abuse treatment and prevention. Action must be taken to correct this.

3. When there are migrant workers in a community, plans of the local health systems agency should address the health needs of these people.

4. In some communities, illegal immigrants from other countries are competing for services designed for Puerto Ricans, because there are not enough services to meet all the needs. This must be corrected to assure fair and adequate access for all in need of services.

5. A closely monitored comprehensive school health curriculum designed and implemented by bilingual-bicultural health educators is needed. This need is especially felt by some Hispanic communities that have a younger median age than the majority of the population. School health education may provide a mechanism to reach entire families through school children.

6. The Public Health Service, Veterans Administration hospitals, and other military hospitals and clinics, which are federally funded, should be directed, advised, and trained in the delivery of services to Hispanic populations.

ELDERLY AMERICANS

The following is a presentation of views expressed by participants during the meeting on strategies for promoting health for Elderly Americans.

A major problem for elderly Americans is inaccessibility of needed medical and preventive health services. This problem affects older persons within all socioeconomic groups. Creative outreach is required to make all services more accessible. If the health promotion goals for the Nation are to be achieved, this problem must be addressed within every community.

Many elderly persons do receive medical care for the treatment of a major illness or its precursors, but are not receiving services that could help to prevent future illness and disability. These individuals might be provided with preventive services through the medical care system. Thus, efforts should be made to gain support from the medical professions for health promotion activities. Because the older person typically uses the medical care system only for illness care, health promotion services also might be provided in settings frequented by the well elderly (e.g., senior centers).

In some rural sections of the country, elderly people who live on incomes at or below the poverty level are an especially vulnerable group, with many health problems that have not been addressed.

The Objectives for the Nation inadequately addressed the specific needs of the elderly. Local control of decisionmaking and resources and more participation by older persons will facilitate adaptation of the objectives to meet the needs of elderly people.

Discussion of Prevention Priority Areas

The participants ranked the five priority areas in each of the three strategy categories (health promotion, health protection, and preventive health services) as shown in Table 4.

Table 4. Ranking of Importance: Elderly Americans

Scale: 1 = high; 5 = low

Promotion/Prevention Areas	Ranking of Importance
Health Promotion	
Smoking Cessation	5
Reducing Misuse of Alcohol and Drugs	4
Exercise and Fitness	2
Improved Nutrition	1
Stress Control	3
Health Protection	
Injury Control	1
Occupational Safety and Health	3
Dental Health Protection	5
Toxic Agent Control	4
Infectious Agent Control	2
Preventive Health Services	
Family Planning	*
Pregnancy and Infant Care	*
Immunizations	3
Sexually Transmissible Disease Services	5
Hypertension Control	2
Sensory Deprivation Control**	1
Periodic Retirement, Lifestyle, and Health Assessment**	4

*Category perceived as unimportant to this group.
**Category added as especially applicable for this group.

Comments by Participants Regarding Specific Priority Areas

Health Promotion

Exercise and Fitness--Exercise is important for the elderly. Physical fitness can enable an elderly person to move about as he or she wishes and to retain an independent lifestyle to a very old age.

Nutrition--Nutrition programs for the elderly can have many benefits including the provision of an adequate diet for maintenance of health, an opportunity for socialization, and an opportunity to learn practical techniques for preparing and adhering to special diets.

Stress Control--The elderly face many stressful situations, which can have deleterious effects on physical and mental health. Common problems faced by the elderly include:

- the frustration of attempting to live on a fixed income during inflationary times,
- social isolation (often compounded by physical disability or sensory deprivation),
- the treat of disability or death, and
- dealing with the death of a spouse or close friends.

Health Protection

Occupational Safety and Health and Dental Health Protection--These prevention activities were mentioned as especially important for younger age groups to help decrease disability in old age.

Toxic Agent Control--Air pollution is a serious problem for many elderly persons, especially those with certain respiratory conditions.

Infectious Agent Control--Hospital-acquired infections are high among the elderly.

Preventive Health Services

Sensory Deprivation Control--Preservation of sight, hearing, and other senses would decrease the rate of injuries, enable the elderly to be more active and less isolated, and decrease dependency and institutionalization. Sensory deprivation is a serious problem and deserves a large allocation of resources because:

- sensory deprivation affects large numbers of the elderly, and
- there are existing preventive and rehabilitative services which, if made more widely available, could effectively reduce this problem.

Recommendations for Implementation Strategies

The following are the specific comments and recommendations of the Elderly American consultation group related to implementation strategies for the objectives on health promotion.

Grants to States and Localities (Health Education/Risk Reduction Grants)

1. Some State governments have in the past shown callousness toward the needs of elderly people. Priority funding should be provided for proposals that indicate involvement of elderly consumer and local groups (including State and Area Agencies on Aging) in planning and implementation.

2. The question was raised as to whether grant projects can do an adequate job in health promotion, or whether the medical community would be a more effective vehicle?

3. State health planning councils have not given sufficient emphasis to concerns of the elderly. Interagency efforts involving the Veterans Administration, State Agencies on Aging, and elderly consumer groups may help identify needs of the older persons.

Research and Demonstrations

Participants indicated many research needs, including further study of the following:

1. the effectiveness of elderly persons trained as peer counselors;

2. appropriate ways to modify behavior specifically for elderly persons;

3. methods of outreach to elderly persons who are not receiving services;

4. alcohol and drug misuse--the extent of the problem, contributing factors, and possible actions;

5. food purchasing patterns and possible problems with packaging and labeling;

6. establishment of an average geriatric medication dose;

7. the effect of drug interactions on individual behavior and on automobile accidents and other injuries;

8. the physical and psychological impact of the death of a spouse and close friends;

9. a literature review on the state of the art regarding health promotion and the elderly;

10. appropriate content for health promotion activities of elderly persons;

11. an appropriate delivery method and funding mechanism for the proposed "periodic retirement, lifestyle, and health assessments."

Monitoring and Surveillance

No specific recommendations or comments were made in this category.

Dissemination

1. Marketing principles should be used to sell health promotion to the medical profession.

2. Radio, religious organizations, and posters in "mom and pop" stores are communication channels that have effectively reached some isolated elderly.

3. The Federal Government should take a more aggressive role regarding outreach to older persons who are not receiving services.

4. The media can be used to inform elderly people of their right to demand accessible services, even when innovative and comprehensive new programs are necessary to provide this accessibility.

5. The Social Security system might be used for dissemination of information.

Technical Assistance

1. The Federal Government should assess the appropriate content for health promotion programs directed to the elderly, and should provide the necessary information to State and local health departments and voluntary organizations to prevent duplication of efforts.

2. Technical assistance is most effectively provided by working through existing community groups, not by attempting to replace them.

Manpower Development

1. Physicians need to become more aware of the role they can play in helping people stay well.

2. Medical students should be encouraged to pursue the specialty field of geriatric medicine.

3. Funds are needed to train lay persons to act as health consumer advocates. More elderly volunteers and community workers could be utilized, especially the retired health professional.

4. Gerontology curricula should provide training in health promotion for the elderly, especially with regard to the effect of specific behaviors on health and methods to modify these behaviors.

5. Continuing education might enable more pharmacists to assist elderly patients with the proper use of medications.

6. Better training in health promotion activities is needed for staff members of long-term care facilities and home health agencies.

7. Home delivered meals volunteers might be trained to recognize certain health-related problems and to suggest appropriate referrals.

Direct Services

1. Many older persons have multiple medical problems. Comprehensive patient-centered care is needed.

2. Coordination is needed so that health promotion programs for the elderly can be designed to work effectively with the Veterans Administration system and the Military Health Care system.

3. There is a need to deliver services where the people are. More direct health services might be provided at senior centers, social clubs, and religious institutions. Assistance is required in transporting elderly people to places where they can obtain health and social services. Programs that reach people in their homes would be beneficial to the elderly.

4. Social and health services should be provided in one comprehensive setting.

5. Older Americans Health Fairs, sponsored primarily by Area Agencies on Aging and local Red Cross chapters, might be expanded to provide more health promotion services. Screening for health problems has been made available for many elderly persons through programs such as this. Screening should be made available for all older persons. Additionally, increased community support, more and better-trained physicians, and more appropriate funding mehcanisms are needed to provide effective, comprehensive follow-up.

6. Two programs (one in New York, the other in Georgia) currently are working through existing organizations to keep the elderly out of institutions.

7. Medicare, Medicaid, and other third-party payers should provide coverage for preventive health services.

AMERICAN INDIANS

The following is a presentation of views expressed by participants during the meeting on strategies for promoting health for American Indians.

In general, American Indians suffer from a greater prevalence of health problems than the population as a whole. High unemployment, poor housing, and other economic and social difficulties contribute to these health problems and also must be addressed. In light of this fact, the relevance of discussing health promotion is questionable. However, health promotion is important to reduce further morbidity/mortality in a population that is already ill and, more significantly, in doing things to keep people well once they <u>are</u> well.

Indian health care services, in general, suffer from inadequate resources. Efforts are being made to improve this. Often the use of available resources could be better planned and coordinated by the Federal agencies involved in rendering health care.

In one recent experience, for example, the Department of Housing and Urban Development made a commitment to build housing for Indians. Indian Health Service funds required for water and sewerage fell prey to budget cuts; and funding for roads, a responsibility of the Bureau of Indian Affairs, was also cut. Also, of 48 Public Health Service Hospitals providing services to Indians, only 32 meet standards for accreditation. In spite of the fact that this population is currently "more ill" than the population as a whole, planning for prevention may provide for better coordination of resources. It is often possible to address preventive health strategies simultaneously with treatment for specific health problems.

Disease patterns among American Indians are shifting from communicable diseases, for which there is more direct interventions, to diseases related to human behavior, for which measures of direct intervention are not as applicable. Health problems of special concern to American Indians include obesity, diabetes, hypertension, accidents, environmental hazards (especially those related to current and future energy development), alcohol-related illnesses, sexually transmitted diseases, and mental health. There are preventive measures applicable to these areas, and there already exists a prevention component in Indian Health Services. Future programs might build upon these services.

Concern was expressed by group members regarding their ability to "represent" the interests of American Indians and Alaskan Natives. There is great diversity in the health status and needs of people within this population group, which includes members of over 200 separate and independent nations, called tribes, that live in urban, rural, and reservation settings throughout the United States. Dr. Lawrence W. Green, Director of OHP and Chairman for the meeting, assured the group that they were convened to offer

individual expertise and experiences as members of the American Indian community, but were not expected to represent nor speak for the total American Indian/Alaskan Native population.

It was further suggested that planning for health promotion and disease prevention measures should begin on a more decentralized basis, e.g., at the regional level, to enhance the participation of more Indian organizations in coordination meetings such as this. Inasmuch as tribal and urban Indian health groups already have developed tribal/urban health plans that identify specific "unmet health needs," such needs should be considered in the final development of strategies for health promotion and disease prevention by the Federal agencies involved in such an undertaking. Finally, the identification of health needs of specific communities at the local level is crucial in shaping health policy plans and in their successful implementation.

Discussion of Prevention Priority Areas

The participants ranked the five priority areas in each of the three strategy categories (health promotion, health protection, and preventive health services) as shown in Table 5.

Table 5. Ranking of Importance: American Indians

Promotion/Prevention Areas	Ranking
Health Promotion	
Smoking Cessation	low
Misuse of Alcohol and Drugs	high
Improved Nutrition	variable
Exercise and Fitness	variable
Stress Control	variable
Health Protection	
Injury Control	high
Occupational Safety and Health	variable
Dental Health Protection	variable
Toxic Agent Control	high
Infectious Agent	variable
Preventive Health Services	
Family Planning	variable
Pregnancy and Infant Care	variable
Immunizations	variable
Sexually Transmissible Disease Services	variable
Hypertension Control	variable

Comments by Participants Regarding Specific Priority Areas

Health Promotion

Smoking Cessation--This area was considered of relatively minor importance to this population group, although the incidence of lung cancer is increasing. Measures of preventive intervention may be more efficient now than later.

Misuse of Alcohol and Drugs--This area was considered of major importance and should be given maximum attention especially as it relates to suicide, homicide, and cirrhosis. Alcohol abuse has reached epidemic proportions in many Indian communities.

Improved Nutrition--Good nutrition is seen as a contributing factor with exercise and fitness in the control of obesity, a significant health problem among American Indians.

Exercise and Fitness--Together with nutrition, exercise can contribute to the control of obesity, a risk factor for many chronic diseases prevalent among Indians. It was noted, however, that obesity may be viewed by some Indians as indicators of good health and, as such, any preventive measures should be culturally sensitive. Exercise also is considered an important prevention activity for American Indian youth and may help in the prevention of drug and alcohol abuse.

Stress Control--This is related to mental health, suicide, and hypertension. Health promotion services associated with coping and mental health should be delivered apart from treatment of alcoholism or mental illness. Because of the social stigma that can result, there is a reluctance to use mental health services as currently delivered.

Health Protection

Toxic Agent Control--Future problems are expected with toxic agents as new energy projects are developed in areas where Indian populations reside. Preventive measures are needed now.

Occupational Safety and Health--Education of many tribes to local hazards is especially needed. Tribes in southwestern States are commonly exposed to mining hazards. The impact of industrial development upon many tribes will increase the relative importance of this category.

Injury Control--The high rate of accidents and injuries is believed to be associated with alcohol abuse and poor road maintenance.

Dental Health Protection--This is especially needed in young children. Although fluoridation is available, many Indians have their own wells. Adequate treatment of dental disease is often unavailable, making prevention even more important.

Infectious Agent Control--Tuberculosis is still a problem in the Indian community. Otitis media and trachoma are of special concern. Diabetes, prevalent among American Indians, increases susceptibility to some infectious agents.

Preventive Health Services

Family Planning--Teenage pregnancies are a problem in both urban and rural areas. There is a need for culturally sensitive educational materials on family planning. A source of bias exists in statistics related to Indian family structure, because a woman must state that the whereabouts of her child's father are unknown to qualify for certain forms of assistance.

Pregnancy and Infant Care--A limiting factor in maternal and child health is a lack of physicians. Education alone is not enough if services for care are neither available nor accessible.

Immunizations--Where there are community health centers, immunization rates for increasing. Outreach activities have contributed to the increase in rates. The rate of immunization among many Indian children, however, is not as high as among the general population. Over-immunization, because of overlapping services, also occurs.

Sexually Transmissible Disease Services--These diseases pose a health problem among the Indian community, but statistics vary from area to area. Sex education of youth also is varied and, in general, is minimal.

Hypertension Control--Hypertension appears to be a major problem and is related, in many cases, to obesity. Hypertension is a problem in urban and reservation areas. In some areas, many people diagnosed as hypertensive do not seem to understand the nature and treatment of high blood pressure.

The above ranking was based on the combined knowledge of group members. Participants cautioned that diverse groups within this population may not agree with these priorities. Programs will need to be targeted to the specific groups most in need.

Recommendations for Implementation Strategies

The following are the specific comments and recommendations of the American Indian consultation group related to implementation strategies for the objectives in health promotion.

Specific Comments and Recommendations

Grants to States and Localities (Health Education/Risk Reduction Grants)

States have no jurisdiction over Indian tribes. Under the current arrangement, these groups are not eligible for funds allocated through local and State governments. In those instances where urban Indian organizations may qualify for funding, the criteria and reporting requirements often are too restrictive, inhibiting application for funding. Suggestions to ensure that some Federal prevention funds reach Indian groups include:

1. secure General Counsel opinion on tribal eligibility;

2. consider providing some funds for health promotion through the Indian Health Service to be allocated to the Indian community directly; and

3. work with tribes and States to look into the question of tribal eligibility and consider amending the legislation, if possible.

Research and Demonstration

1. Indians are skeptical of the usefulness to them of previous research and anthropological studies, and are more interested in program and protocol development than basic research.

2. Indian people should be included in the planning of all research projects.

3. Research should be done by Indians, where possible. The Federal Government might provide technical assistance when needed. Community colleges can provide expertise.

4. Research data and reports should be disseminated to the Indian population on the local level, where the findings can be useful.

5. Data collection methods must be culturally sensitive. Cultural relevance differs from group to group and must be considered in all phases of project planning and implementation.

6. Include Indian health boards and community groups in planning health programs at the local, area, tribal, and national levels.

7. Research is especially needed in the following:

   a) factors contributing to the high rate of diabetes and alcoholism among Indian people;

   b) evaluation (cultural relevance and effectiveness for Indian people) of educational materials and behavior change strategies;

   c) appropriateness of traditional Indian physical and mental health care for today's health problems; and

   d) health needs of the rural (nonreservation) Indian population.

7. Statistical information that can be utilized in planning for health promotion activities and in sharpening the "objectives" for this population group may be found in the following Federal documents:

   a) Indian Health Trends and Services, 1978 Edition, Indian Health Service (DHEW HSA 78-12009).

   b) The Indian Health Care Improvement Act (P.L. 94-437, Annual Report for Fiscal Year 1978 (DHEW HSA 80-1016).

   c) A Comprehensive Health Plan for American Indians and Alaska Native People for Fiscal Years 1981-1984, report presented to Congress in conformance with P.L. 94-437. (This report, a compilation of 216 tribal health plans and 41 urban Indian health plans, can be obtained from Mr. Wes Halsey at the Indian Health Service's Office of Indian Community Development at 301-443-6840.)

   d. Congressional Monitoring of Planning for Indian Health Care Facilities is Still Needed, General Accounting Office Report HRD 80-28, April 16, 1980.

Monitoring and Surveillance

1. Statistics from local health systems agencies do not reflect Indian health needs; Indian Health Service statistics are considered more useful.

2. State Indian organizations can provide better monitoring of urban Indian programs than State and local governments. The National Indian Health Board and the National Tribal Chairmen's Association should be instrumental in devising monitoring mechanisms.

3. Outreach to underserved people should be considered for more accurate data collections. Surveys done at service delivery sites do not reflect the needs of those who are not receiving services.

4. Indigenous community health representatives or other Indian workers should participate in data collection and analysis.

5. Items relating to risk factors and health behavior should be added to periodic surveys conducted by the Indian Health Service.

Dissemination

1. Tribal and urban Indian organizations should be involved in the adaptation of media messages for specific Indian populations.

2. Bilingual and culturally targeted materials and media messages should be provided.

3. Indian communicators and models should be used.

4. The unique communication channels that exist on reservations--for example, district dinners and tribal fairs--should be used.

5. One percent evaluation funds should be used to evaluate existing Indian Health Service communications.

6. The Buy Indian Act and The Indian Self-Determination Act should be used as the basis for noncompetitive contracting with Indian organizations.

7. The Health Services Administration (HSA) should work through the American Indian Health Care Association for the dissemination of information to all urban Indian health projects.

Technical Assistance

1. Indian nonprofit and profit-making organizations should be used to provide relevant technical assistance.

2. Technical assistance is especially needed for the development of written materials for program implementation, training, and program evaluation.

3. The Indian Health Service, national Indian organizations, and tribal consultant groups can help to disseminate information on the availability of technical assistance.

Manpower Development

1. Short-term refresher training on health promotion issues is needed for indigenous health personnel.

2. Cultural awareness training should be required for non-indigenous personnel.

3. Since physicians are in short supply, health education might be provided by nurses or allied health workers.

Direct Services

1. Direct health services are currently provided by:

   a) Public Health Service Hospitals (urban and nonreservation Indians);

   b) Indian Health Service Hospitals, health centers, and numerous outreach clinics;

   c) Federal employee health clinics;

   d) the Alaska State Health Department; and

   e) tribally operated clinics (not a direct Federal service).

2. Direct services presently are spread too thin--better coordination of services would allow for the addition of preventive services.

APPENDIX

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